		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040808

Facility Name: Roosevelt Square-Murphysboro

Address: 1501 Shomaker Drive (Number) Murphysboro (City) 62966 (Zip Code)

County: Jackson

Telephone Number: (618) 684-2693 **Fax #** ( )

IDPA ID Number: 611278144001

Date of Initial License for Current Owners: 05/01/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Terri Bell **Telephone Number:** (502) 394-2158

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Steven B. Mowery
(Title) Vice President of Reimbursement

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	76	Intermediate/DD	76	27,816	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	22,750			22,750	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,750			22,750	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.79%

D. How many bed-hold days during this year were paid by Public Aid?
12 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	102,987	10,895	4,305	118,187		118,187		118,187			1
2	Food Purchase		113,340		113,340		113,340	(219)	113,121			2
3	Housekeeping	62,067	6,207		68,274		68,274		68,274			3
4	Laundry	67,016	10,684		77,700		77,700		77,700			4
5	Heat and Other Utilities			47,995	47,995		47,995	485	48,480			5
6	Maintenance	17,974	6,082	16,812	40,868		40,868	(2,284)	38,584			6
7	Other (specify):*											7
8	**TOTAL General Services**	250,044	147,208	69,112	466,364		466,364	(2,018)	464,346			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	955,968	26,106	26,946	1,009,020		1,009,020		1,009,020			10
10a	Therapy		4,488	24,205	28,693		28,693		28,693			10a
11	Activities	23,190	35		23,225		23,225		23,225			11
12	Social Services	28,106			28,106		28,106		28,106			12
13	Nurse Aide Training	22,946			22,946		22,946		22,946			13
14	Program Transportation			(6,704)	(6,704)		(6,704)		(6,704)			14
15	Other (specify):*			743,610	743,610		743,610	(743,610)				15
16	**TOTAL Health Care and Programs**	1,030,210	30,629	788,057	1,848,896		1,848,896	(743,610)	1,105,286			16
	C. General Administration											
17	Administrative	59,968			59,968		59,968		59,968			17
18	Directors Fees							246	246			18
19	Professional Services			(7,476)	(7,476)		(7,476)	30,482	23,006			19
20	Dues, Fees, Subscriptions & Promotions			12,807	12,807		12,807	1,593	14,400			20
21	Clerical & General Office Expenses	41,801	(3,373)	20,952	59,380		59,380	193,712	253,092			21
22	Employee Benefits & Payroll Taxes			241,847	241,847		241,847	15,270	257,117			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,760	9,760		9,760	6,835	16,595			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			10,975	10,975		10,975	170	11,145			26
27	Other (specify):*											27
28	**TOTAL General Administration**	101,769	(3,373)	288,865	387,261		387,261	248,308	635,569			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,382,023	174,464	1,146,034	2,702,521		2,702,521	(497,320)	2,205,201			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Roosevelt Square-Murphysboro #0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			62,021	62,021		62,021	8,481	70,502			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			40,092	40,092		40,092	2,675	42,767			33
34	Rent-Facility & Grounds							2,673	2,673			34
35	Rent-Equipment & Vehicles			15,867	15,867	(492)	15,375	11,048	26,423			35
36	Other (specify):*											36
37	**TOTAL Ownership**			117,980	117,980	(492)	117,488	24,877	142,365			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			154,422	154,422		154,422		154,422			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			154,422	154,422		154,422		154,422			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,382,023	174,464	1,418,436	2,974,923	(492)	2,974,431	(472,443)	2,501,988			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$ 743,610		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	219			4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	225			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	7,211			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Credit taken in prior year	(20,923)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 730,342		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	257,899		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 257,899		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 988,241		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Roosevelt Square-Murphysboro

ID# 00-40808

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Day Habilitation	$ (743,610)	15	1
2	Offset Meals Revenue with Food	(219)	2	2
3	Non-allowable Expenses	(7,211)	19	3
4	Credit taken in prior year	20,923	19	4
5	Non-allowable Dues	(225)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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78				78
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80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(730,342)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(219)	0	0	0	0	0	0	0	0	0	0	(219)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	485	0	0	0	0	0	0	0	0	0	485	5
6	Maintenance	0	(2,284)	0	0	0	0	0	0	0	0	0	(2,284)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(219)	(1,799)	0	0	0	0	0	0	0	0	0	(2,018)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(743,610)	0	0	0	0	0	0	0	0	0	0	(743,610)	15
16	**TOTAL Health Care and Programs**	(743,610)	0	0	0	0	0	0	0	0	0	0	(743,610)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	246	0	0	0	0	0	0	0	0	0	246	18
19	Professional Services	13,712	16,770	0	0	0	0	0	0	0	0	0	30,482	19
20	Fees, Subscriptions & Promotions	(225)	1,818	0	0	0	0	0	0	0	0	0	1,593	20
21	Clerical & General Office Expenses	0	193,712	0	0	0	0	0	0	0	0	0	193,712	21
22	Employee Benefits & Payroll Taxes	0	15,270	0	0	0	0	0	0	0	0	0	15,270	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,835	0	0	0	0	0	0	0	0	0	6,835	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	170	0	0	0	0	0	0	0	0	0	170	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	13,487	234,821	0	0	0	0	0	0	0	0	0	248,308	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(730,342)	233,022	0	0	0	0	0	0	0	0	0	(497,320)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Roosevelt Square-Murphysboro **#** 0040808 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	8,481	0	0	0	0	0	0	0	0	0	8,481	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	2,675	0	0	0	0	0	0	0	0	0	2,675	33
34	Rent-Facility & Grounds	0	2,673	0	0	0	0	0	0	0	0	0	2,673	34
35	Rent-Equipment & Vehicles	0	11,048	0	0	0	0	0	0	0	0	0	11,048	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	24,877	0	0	0	0	0	0	0	0	0	24,877	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(730,342)	257,899	0	0	0	0	0	0	0	0	0	(472,443)	45

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ResCare, Inc.	100	ICF/DD Group Homes & Nursing Home Only)				
(Owns 100% of ResCare Illinois, Inc.)		(Non-Residential & Non-Health Omitted)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Admin Salaries & Services	$	ResCare, Inc.	100.00%	$ 193,712	$ 193,712	1
2	V	22	Payroll Taxes & Benefits		ResCare, Inc.	100.00%	15,270	15,270	2
3	V	24	Travel and Lodging		ResCare, Inc.	100.00%	6,835	6,835	3
4	V	30	Depreciation		ResCare, Inc.	100.00%	8,481	8,481	4
5	V	6	Maintenance		ResCare, Inc.	100.00%	(2,284)	(2,284)	5
6	V	5	Utilities		ResCare, Inc.	100.00%	485	485	6
7	V	26	Insurance		ResCare, Inc.	100.00%	170	170	7
8	V	34	Building Lease		ResCare, Inc.	100.00%	2,673	2,673	8
9	V	35	Equipment Lease		ResCare, Inc.	100.00%	11,048	11,048	9
10	V	18	Directors Fees		ResCare, Inc.	100.00%	246	246	10
11	V	20	Public Relations		ResCare, Inc.	100.00%	1,818	1,818	11
12	V	33	Taxes		ResCare, Inc.	100.00%	2,675	2,675	12
13	V	19	Professional Services		ResCare, Inc.	100.00%	16,770	16,770	13
14	Total			$			$ 257,899	$ * 257,899	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ResCare, Inc.
Street Address: 10140 Linn Station Rd.
City / State / Zip Code: Louisville, KY 40223
Phone Number: (502) 394-2100
Fax Number: (502) 394-2353

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Admin Salaries & Services	Days	2,025,971		$ 15,469,527	$ 15,469,527	25,370	$ 193,712	1
2	22	Payroll Taxes & Benefits	Days	2,025,971		1,058,662		29,222	15,270	2
3	24	Travel and Lodging	Days	2,025,971		374,563		36,970	6,835	3
4	30	Depreciation	Days	2,025,971		746,629		23,013	8,481	4
5	6	Maintenance	Days	2,025,971		(240,926)		19,206	(2,284)	5
6	5	Utilities	Days	2,025,971		40,932		24,005	485	6
7	26	Insurance	Days	2,025,971		11,651		29,560	170	7
8	34	Building Lease	Days	2,025,971		220,399		24,571	2,673	8
9	35	Equipment Lease	Days	2,025,971		963,656		23,227	11,048	9
10	20	Directors Fees	Days	2,025,971		22,623		22,030	246	10
11	33	Public Relations	Days	2,025,971		129,128		28,524	1,818	11
12	19	Taxes	Days	2,025,971		237,962		22,775	2,675	12
13	18	Professional Services	Days	2,025,971		1,345,448		25,252	16,770	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 20,380,254	$ 15,469,527		$ 257,899	25

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	NOT APPLICABLE											2
3												3
4												4
5												5
	Working Capital											
6												6
7	NOT APPLICABLE											7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11	NOT APPLICABLE											11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Roosevelt Square-Murphysboro **#** 0040808 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	47,983	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	(47,983)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	88,075	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	40,092	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996	45,552	9
1997	46,566	10
1998	40,095	11
1999	42,713	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,366 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	4.06 Acres	1995	$ 8,000	1
2					2
3	TOTALS	4.06 Acres		$ 8,000	3

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		1995	1972	$ 534,601	$ 21,384	25	$ 21,384	$	$ 119,394	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof			1995	3,300	330	10	330		1,788	9
10	Storage Shed			1995	1,301	130	10	130		683	10
11	20% Down Roof			1995	5,100	510	10	510		2,550	11
12	Roof			1996	20,444	2,044	10	2,044		9,881	12
13	Vinyl Flooring			1996	1,282	128	10	128		609	13
14	Laundry Room Modification			1996	4,223	422	10	422		2,006	14
15	Laundry Room Modification			1996	3,450	345	10	345		1,581	15
16	Water Heater			1998	532	106	5	106		213	16
17	3 Ton Heater			1999	3,800	380	10	380		475	17
18	Wire Shelves			1997	532	53	10	53		204	18
19	Bathroom			1997	4,312	431	10	431		1,581	19
20	Rewire Building Receptacles			1998	1,000	100	10	100		292	20
21	Smoke Detector			1998	1,595	160	10	160		452	21
22	Showers			1998	7,900	790	10	790		2,107	22
23	Central Air			1998	6,889	689	10	689		1,722	23
24	Building Remodel			1999	7,355	736	10	736		1,287	24
25	Heating/Cooling Unit			1999	2,354	235	10	235		392	25
26	Electrical System Upgrade			1999	109,090	10,909	10	10,909		18,182	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 719,060	$ 39,882		$ 39,882	$	$ 165,399	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 86,997	$ 12,811	$ 12,811	$	5	$ 69,822	37
38	Current Year Purchases	57,440	9,328	9,328		5	34,326	38
39	Fully Depreciated Assets	(3,275)						39
40	Home Office Allocation		8,481	8,481		5	8,481	40
41	TOTALS	$ 141,162	$ 30,620	$ 30,620	$		$ 112,629	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 868,222	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 70,502	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 70,502	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 278,028	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Building Owned

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description: Copier $2,475; Postage $676; Dishwasher $828
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2000 Ford E-350	$ 921.25	$ 11,396	17
18			Payment varies		18
19			due to depreciation		19
20			expense		20
21	TOTAL		$ 921.25	$ 11,396	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 45

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		24,941		24,941
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 24,941	$	$ 24,941
10	SUM OF line 9, col. 1 and 2 (e)	$ 24,941			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	510,090		3
4	Supply Inventory (priced at)	19,104		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): I/C Receivable	2,497,380		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,026,574	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	8,000		13
14	Buildings, at Historical Cost	534,601		14
15	Leasehold Improvements, at Historical Cost	184,459		15
16	Equipment, at Historical Cost	141,162		16
17	Accumulated Depreciation (book methods)	(278,028)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	298		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 590,492	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,617,066	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,079,684	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,707		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,064		31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,075		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,225,530	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,225,530	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,391,536	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,617,066	$	48

***(See instructions.)**

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,023,593	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,023,593	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	367,943	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 367,943	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,391,536	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,599,037	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,599,037	3
	B. Ancillary Revenue		
4	Day Care	743,610	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 743,610	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	219	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 219	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,342,866	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	466,364	31
32	Health Care	1,848,896	32
33	General Administration	387,261	33
	B. Capital Expense		
34	Ownership	117,980	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	154,422	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,974,923	40
41	**Income before Income Taxes (line 30 minus line 40)****	367,943	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 367,943	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,679	1,848	$ 34,494	$ 18.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	10,876	11,620	129,046	11.11	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	1,797	1,836	22,946	12.50	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,127	2,329	23,190	9.96	10
11	Social Service Workers	1,937	2,169	28,106	12.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,495	13,689	102,987	7.52	15
16	Dishwashers					16
17	Maintenance Workers	2,082	2,327	17,974	7.72	17
18	Housekeepers	7,825	8,508	62,067	7.30	18
19	Laundry	9,003	9,600	67,016	6.98	19
20	Administrator	1,851	1,987	59,968	30.18	20
21	Assistant Administrator					21
22	Other Administrative	3,948	4,295	41,801	9.73	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	11,240	12,301	135,826	11.04	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	82,259	88,382	656,602	7.43	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	149,119	160,891	$ 1,382,023 *	$ 8.59	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	123	$ 4,305	1	35
36	Medical Director	***	19,497	10	36
37	Medical Records Consultant	24	1,188	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant	85	2,131	10	39
40	Physical Therapy Consultant	78	3,900	10a	40
41	Occupational Therapy Consultant	73	5,442	10a	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	204	8,147	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Dental	103	4,131	10	47
48	Pyschology	90	6,716	10a	48
49	TOTAL (lines 35 - 48)	779	$ 55,457		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dougas Beebe	Administrator	0	$ 59,968
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,968

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Payroll Processing	$ 6,236
Non-allowable Expenses	Manual Entry	7,211
Credit taken in prior year	Manual Entry	(20,923)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ (7,476)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,621
Unemployment Compensation Insurance	
FICA Taxes	102,997
Employee Health Insurance	68,992
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Unemployment Taxes	20,651
Life Insurance	1,356
LTD/LOT Benefits	1,491
Pension Benefits	8,514
Employee Inoculation	2,367
Tuition Reimb Benefits	859
Corporate Overhead	15,270
TOTAL (agree to Schedule V, line 22, col.8)	$ 257,118

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,332
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues and Subsriptions	8,475
Corporate Overhead	1,593
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,400

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,985
Corp Overhead	6,835
In-State Travel	5,132
Seminar Expense	1,643
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,595

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	NOT APPLICABLE												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Roosevelt Square-Murphysboro # 0040808 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **219**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG Peat Marcwick** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.